Medical Homes Framework for Payment Subcommittee Meeting 10.12.2011

In Person: Dr. Fred Olson, BCBS of MT; **Dr. Bob Shepard**, New West Health Insurance; **Dr. Jonathan Griffin**, St. Peter's Medical Group; **Bob Marsalli**, MT Primary Care Association; John Hoffland, Montana Medicaid

On the Phone: Dr. Doug Carr, Billings Clinic; Bill Pfingsten, Bozeman Deaconess Health Group; **Kirsten Mailoux**, EBMS; **Dr. Jay Larson**, Independent Provider; **Dr. Janice Gomersall**, MT Academy of Family Physicians; **Dr. Tom Roberts**, Western Montana Clinic; Lisa Wilson, PLUK; Dr. Rob Stenger, Grant Creek Family Practice, St. Patrick's Hospital

1. Structural

There needs to be an extra stream of reimbursement for additional services that may be required for patients and additional incentives to keep the practice providing quality care. The structure for the enhanced reimbursement would have fee for service payments continue and add additional payments which would be linked to the member. The reimbursement would need to be at a level to allow for the provider to reinvest in their PCMH.

The components of the additional payments would include 1) participation, 2) care management, and 3) quality improvement incentive.

1) Participation fees include all non RVU activities- telephone, email, review of records, coordinating care, talking to family members, etc. . The simplest way to do the participation fee would be a flat monthly fee and then the care management would be billed separately. The participation payment needs to be sufficient enough across the population to include everything an average risk patient would need. A participation fee goes over the entire continuum, including the high-risk patients. The insurers would agree to pay a certain amount for everyone they cover so that the medical home has a stable amount of money to provide services. Providers would still get fee for service payment for face to face time with the complicated patients; an additional bill would be submitted for them because they would be eligible for a care coordination payment. The most efficient way to do the PMPM could be to just have the payer calculate it, rather than have the provider submit it. However, on the case of diagnosis, more would need to be done on case management

2) Care management would be based on a qualifying diagnosis and recognize chronic disease care. The fee for the care coordination piece could also be submitted quarterly. A member suggested a payment framework be based on levels of patients tiered on how often they see their provider and whether they have chronic illnesses or not. Then providers would be paid based on how many patients on the various levels are seen.

A health risk assessment needs to be done at the beginning of the medical home so that the risk can be stratified including a lot more information about individual patients where case management can take place. A member expressed concerns that including risk assessment could make the system too complicated, too difficult to get the program off the ground and hard for providers to get paid

accurately – he suggested a simpler method of a yearly care coordination code. Care coordination and case management need to be clearly defined so we know how to assign payment. Patient incentives and engagement will definitely be part of this later on once medical homes are established because the concept of medical homes is not successful unless the patient is engaged and educated about them.

3) Quality incentives are where the benchmarking might occur –Quality incentives need six months to a year to measure and need to be addressed annually. Whatever system we come up with needs to be efficient; we don't want the benefits of medical homes being eaten up by overhead costs.

Finally, there needs to be a mechanism for creating the transaction. BCBS suggested that the provider bill the payer once a year for all of the fees. EBMS envisioned a quarterly payment system. Providers were concerned that if the cash flow wasn't consistent enough practices wouldn't stay involved. Medicaid does a monthly PMPM that is simply based on their registered providers in the system. They do this for passport and two subsets of passport, including health management and chronic care programs, as well as drug use program.

The subcommittee agreed that the payment structure has to follow the practice-based reform we are working on. The educational outreach component could be absorbed by the payers, the providers, or both.

2. <u>Attribution</u>

It is important for the payer to encourage the concept of the PCMH delivery model through patient declaration and enrollment. Patients need to be educated about medical homes and how to use them properly. Using an algorithm on the larger part of the population that is a low utilizing group of medical services will not work well. Even the small percentage of the population that uses medical services is not required to declare a PCP. The preventative care outreach is the most crucial aspect of getting people involved in the system who aren't already.

About 80% of Medicaid Passport patients choose their providers and the rest are auto assigned based on family connections, history, or other relative criteria. The patient declaration for PPO is not required in BCBS plans. New West has the capacity within their platform to capture the patient declared PPO if they wanted to pay on a per member system, but they don't enforce or require declaration, they only use it if it is provided.

Providers and payers need to be synergized in education for patient enrollment. Easy access for patients to healthcare is essential and we cannot have that without an appropriate technology platform.

3. <u>Timelines and phasing</u>

The measurement of quality is nearly a year out. In an initial phase it would be easier to have a fairly broad gate for participation which could narrow down later based on NCQA recognition. Enabling broad initial provider enrollment could be very challenging based on which data system is chosen. Some systems do pay on level of NCQA certification and Medicare is beginning to do that as well.

There will be a call with CMS tomorrow at 11am our time for information on their plans for RFP.

The next framework for payment subcommittee meeting will be on October 26th.